CCA-1224A FORFF (10-22)

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Child Care

FAST PASS DCS REFERRAL
ONE FORM PER CHILD

An Urgent Fast Pass Child Care Referral indicates an urgent child care need to ensure safety, prevent removal, or prevent placement disruption. DES waives the income eligibility and DES-required copayment for this child. However, all families may be responsible for charges if a provider's rate exceeds allowable state reimbursement maximums and/or the provider has other additional charges.

☐ After-Hours ☐ Weekends ☐ Holiday Date: _____

CHILD INFORMATION

Child's ID and Name *(Last, First, M.I.)*: _____ HLCI Participant Number: _____

Soc. Sec. No: _____ Birth Date: _____ Sex (M-F): _____ Ethnicity: _____

Case Status: ☐ Open/On-Going ☐ Closed at Investigation Case Record Name: _____

DCS Specialist's Name *(Last, First, M.I.)*: _____

Mail Drop: _____ Phone No.: _____ Ext.: _____

SECTION - A PLACEMENT

☐ In-Home Placement ☐ Out-of-Home Placement

Placement Name *(Last, First, M.I.)*: _____

Soc. Sec. No: _____ Birth Date: _____ Sex (M-F): _____ Ethnicity: _____

Address *(No., Street, City, State, ZIP Code)*: _____ Phone No.: _____

Written Lang Pref – Parent: _____

Mailing Address *(No., Street, City, State, ZIP Code)*: _____

Message Phone No.: _____

SECTION – B PRIMARY REASON FOR CHILD CARE SERVICES

☐ Work ☐ DCS Training/Courts/Staffing/FCRB ☐ School ☐ Socialization ☐ Caretaker Appointments

SECTION – C CHILD CARE PROVIDER INFORMATION

(Child care is NOT provided to children residing in a DCS foster group home.)

***NOTE TO CHILD CARE PROVIDER:* This referral is approval for the child to attend care. This referral replaces the DES verbal authorization and ensures payment for the child named above. You will receive a Certificate of Authorization for 23P. You may bill each day the child attends 15 minutes or more in a day, up to 23 days per month.**

Start Date: _____

(Any unique needs or instructions for this child should be discussed with the child care provider)

☐ **This child has special needs (IEP, IFSP, ISP, 504 Plan, Healthcare, Other)**

Child Care Provider's Name: _____ Phone No.: _____

Location Address *(No., Street, City, State, ZIP Code)*: _____

A SECOND CHILD CARE PROVIDER IS OPTIONAL. LIST ONLY IF NEEDED.

2nd Child Care Provider's Name: _____ Phone No.: _____

Location Address *(No., Street, City, State, ZIP Code)*: _____

Special Instructions: _____

_____

Signature *(DCS Specialist completing this form)*: _____

****This form must be sent same day of form completion to:** CCA-DCS-Referrals@azdes.gov

Routing: Original-DCS - Yellow Copy-DES Child Care Provider - Pink Copy-Placement/Parent